Heritage National Healthplan, Inc.
TennCare Operations

For the Period
January 1, 1996, Through December 31, 1997

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February 17, 1999

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
Mr. Brian Lapps, Sr., Director
Bureau of TennCare
Department of Health
729 Church Street, Fifth Floor
Nashville, Tennessee 37247

Ladies and Gentlemen:

Pursuant to the agreement between the Comptro ller of the Treasury and the Department of Health, the Division of State Audit performs examinations of managed care organizations participating in the Tennessee TennCare Program under Title XIX of the Social Security Act.

Submitted herewith is the report of the examination of Heritage National Healthplan, Inc., for the period January 1, 1996, through December 31, 1997.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/pn
98/080

cc: Joe Keane
Theresa Clarke-Lindsey

State of Tennessee

Audit Highlights

Comptroller of the Treasury — Division of State Audit

TennCare Report

Heritage National Healthplan, Inc.

For the Period January 1, 1996, through December 31, 1997

Findings

Deficiencies in Claims-Processing System

Heritage National Healthplan, Inc., (Heritage), did not fulfill contract reporting requirements and processing-efficiency requirements specified by the TennCare contract. Deductibles and copayments were incorrectly charged to TennCare "uninsured" members for services the TennCare contract excluded from application of copayments and deductibles. Copayment percentages that were determined by the member's eligibility status were not properly applied. Some claims were paid according to incorrect fee schedules or contract pricing methodologies. All lines on claims were not considered for payment. Inadequate encounter data was reported to TennCare. Errors were discovered in the explanation of benefits sent to TennCare members. Actual receipt dates of claims from the mailroom were not recorded as the receipt date in the claims-processing system (page 6).

Deficiencies in Provider Contract Language

Heritage did not include in the provider agreements all requirements specified by the TennCare contract (page 9).

"Audit Highlights" is a summary of the report. To obtain the complete report which contains all findings, recommendations, and management comments, please contact

Comptroller of the Treasury, Division of State Audit
1500 James K. Polk Building, Nashville, TN 37243-0264
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TennCare Report
Heritage National Healthplan, Inc.
For the Period January 1, 1996, Through December 31, 1997

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TennCare Report
Heritage National Healthplan, Inc.
For the Period January 1, 1996, Through December 31, 1997

INTRODUCTION

PURPOSE AND AUTHORITY OF THE EXAMINATION

The terms and conditions for authorizing the TennCare Program, as well as the contracts between the State of Tennessee and the managed care organizations (MCOs), require that examinations of the managed care organizations be conducted by the Tennessee Comptroller's Office. The contract between the Tennessee Department of Health and the Comptroller's Office also contains a provision requiring the examinations.

Under their contract with the state, the MCOs have asserted that they are in compliance with stated requirements regarding their provision of services to TennCare enrollees. The purpose of our examination is to render an opinion on the MCOs' assertions that they have complied with certain financial-related requirements of their contract with the state.

BACKGROUND

The Tennessee Department of Health is the single state agency responsible for administering the TennCare Program and the TennCare Partners Program. On January 1, 1994, the TennCare Program began as an approved federal waiver replacing the then existing Medicaid Program. TennCare encompasses all services other than mental health and long-term care. On July 1, 1996, the TennCare Partners Program was initiated. TennCare Partners, which functions in the same manner as the regular TennCare Program, covers mental health services. Long-term care continues to be excluded from all TennCare waivers. The state contracts with private health maintenance organizations to provide TennCare services to beneficiaries. The health maintenance organizations are referred to as managed care organizations (MCOs).

Recipients who meet Medicaid eligibility standards are enrolled in the TennCare Program and TennCare Partners Program. In addition, certain uninsured and uninsurable individuals are eligible for enrollment. Uninsured persons may be required to pay a monthly premium. The contracting MCOs provide care for TennCare enrollees for a stated monthly capitation fee. The MCOs in turn arrange for a network of hospitals, doctors, and other health care providers to furnish health care services for persons enrolled in the plan. Essentially, the program functions much the same as a conventional health care delivery system under managed care.

Heritage is a wholly owned subsidiary of John Deere Health Care, Inc., which in turn is a wholly owned subsidiary of Deere & Company. Effective January 1, 1994, Heritage contracted with the State of Tennessee as a health maintenance organization (HMO) to provide medical services under the newly established TennCare Program. The plan's enrollment in the TennCare Program was approximately 23,000 members at December 31, 1996, and approximately 23,800 members at December 31, 1997.

As a HMO, Heritage files quarterly and annual statements with the Department of Commerce and Insurance. The department uses the information filed in these reports to determine if the health maintenance organization meets the minimum requirements for statutory reserves. The statements are filed on a statutory basis of accounting, which differs from generally accepted accounting principles in that "admitted" assets must be easily converted to cash to pay for outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and are reduced from equity. At December 31, 1996, the plan had a restricted deposit of $1,300,000 to satisfy requirements of the Department of Commerce and Insurance. At December 31, 1997, the plan maintained a restricted deposit of $1,575,000 pledged with the Department of Commerce and Insurance. Heritage was notified by the Department of Commerce and Insurance to increase its statutory deposit by $25,000 to satisfy the minimum deposit requirement of $1,600,000.

The annual statement for the year ended December 31, 1996, reported $151,593,550 in plan assets, $83,643,599 in liabilities, and $67,949,951 net worth. Heritage TennCare Operations reported total revenues of $27,263,382 and total expenses of $24,477,338, resulting in a net income of $2,786,044 for the year ended December 31, 1996. Revenue consisted of $26,875,029 in premiums received from TennCare and $388,353 in miscellaneous revenue. Expenses consisted of $20,446,083 in medical expenses and $4,031,255 in administrative expenses.

The annual statement for the year ended December 31, 1997, reported $154,655,100 in plan assets, $100,579,807 in liabilities, and $54,075,293 net worth. Heritage TennCare Operations reported total revenues of $37,917,611 and total expenses of $46,421,518, resulting in a net loss of $8,503,907 for the year ended December 31, 1997. Revenue consisted of $36,961,873 in premiums received from TennCare and $955,738 in miscellaneous revenue. Expenses consisted of $40,769,237 in medical expenses and $5,652,281 in administrative expenses.

SCOPE OF THE EXAMINATION

Our examination covers certain financial-related requirements of the contract between the state and Heritage for the period January 1, 1996, through December 31, 1997. The requirements covered are referred to under management's assertions specified later in the Independent Accountants' report. Our examination does not cover those portions of the contract concerning quality of care, clinical, and medical requirements.

PRIOR EXAMINATION FINDINGS

The previous review of Heritage for the year ended De cember 31, 1995, included a finding on deficiencies in its claims-processing system. Heritage did not fulfill contract reporting requirements and processing-efficiency requirements for TennCare operations. The claims-processing system did not record all procedure codes and charges for certain claims for medical services. Claims were not paid according to the correct fee schedule and were denied even when insurance coverage was effective. The prior finding will be repeated in the current report (see the Findings and Recommendations section of this report).

SUBSEQUENT EVENTS

Subsequent material events and correction of errors discovered by the division of State Audit for 1997 revenues and expenses will affect the reporting of the TennCare operations of Heritage. The TennCare statement of revenue and expenses was adjusted by the Division of State Audit as follows:

- Money was received from the Bureau of TennCare during 1998 for the review period for a retroactive rate increase of $744,646.

- Provider-withhold expense was overstated by $869,904.

- Premium taxes of $32,291 and management fee expenses of $209,892 were increased to reflect the accrual of the retroactive rate increase and correction of the provider-withhold expense.

The effect of these adjustments on the net income for the TennCare operations of Heritage is a decrease in the net loss from $8,503,909 to $7,131,542 as of December 31, 1997. The effect of these adjustments will increase equity for Heritage and, therefore, will not affect minimum net worth requirements.

Independent Accountants' Report
December 14, 1998

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
Mr. Brian Lapps, Sr., Director
Bureau of TennCare
Department of Health
729 Church Street, Fifth Floor
Nashville, Tennessee 37247

Ladies and Gentlemen:

We have examined management's assertions, included in its representation letter dated June 3, 1998, that Heritage complied with the following requirements during the year ended December 31, 1996, and the year ended December 31, 1997.

- Assets and liabilities are properly classified as "admitted" or "non-admitted" on the annual National Association of Insurance Commissioners (NAIC) report which is completed on a "statutory basis of accounting" and filed with the state.

- The organization is in compliance with the minimum equity requirements as specified in the contract with the state.

- The organization has complied with its contractual duty to provide certain member services to its enrollees such as membership cards, provider directories, assignment of a primary care provider, and information on filing grievances.

As discussed in management's representation letter, management is responsible for ensuring compliance with those requirements. Our responsibility is to express an opinion on management's assertions about the organization's compliance based on our examination.

Our examination was made in accordance with standards established by the American Institute of Certified Public Accountants and, accordingly, included examining, on a test basis, evidence about Heritage's compliance with those requirements and performing such other procedures as we considered necessary under the circumstances. We believe that our examination provides a reasonable basis for our opinion. Our examination does not provide a legal determination on Heritage's compliance with specified requirements.

Our examination disclosed the following material noncompliance applicable to Heritage:

- The organization did not comply with contractual claims-processing requirements.
- The organization did not comply with contractual reporting requirements.
- The organization did not comply with contractual requirements concerning its agreements with subcontractors and providers.

In our opinion, except for the material noncompliance described above, management's assertions that Heritage complied with the aforementioned requirements for the year ended December 31, 1996, and the year ended December 31, 1997, are fairly stated in all material respects.

This report is intended solely for the use of the Tennessee General Assembly and the Tennessee Department of Health. However, this report is a matter of public record and its distribution is not limited.

Sincerely,

Arthur A. Hayes, Jr., CPA, Director
Division of State Audit

AAH/pn

FINDINGS AND RECOMMENDATIONS

1. Deficiencies in claims-processing system

Finding

Heritage did not fulfill contract reporting and processing-efficiency requirements. A review of a sample of 50 claims for services provided from January 1, 1996, through December 31, 1997, revealed the following:

a. The following errors were discovered in the explanation of benefits (EOB) sent to the TennCare members for the claims selected for testing. An EOB is a written communication to the TennCare member concerning any amounts the members may owe the medical provider.

- Three claims were correctly denied by Heritage since Medicare was the primary insurer. However, the EOBs for these claims incorrectly communicated that the TennCare member owed an amount to the provider.

- For one claim, the EOB communicated to the Medicaid-eligible member that she was responsible for the charges associated with an emergency room visit, even though the TennCare contract does not allow Heritage to charge Medicaid-eligible members deductibles or copayments.

- The EOB Heritage provided did not always clearly communicate to TennCare members the amounts the members owed the medical provider. For one claim, the EOB reported that the claim was denied with the explanation "uninsured - non-emergency service. Bill patient only the copay of $25.00." The EOB also stated that the TennCare member owed the provider the full charge for the emergency room service of $28.00, but indicated in a separate area that the member was responsible for only a $14.00 copayment.

b. The following processing and payment errors were discovered in the 50 claims selected for testing:

- For two claims, the denial by Heritage was improper.

  - One claim was an emergency room visit which resulted in an inpatient stay. Heritage initially denied the claim for being "out of area" and failed to reprocess and pay it for one year. The TennCare contract requires Heritage to provide emergency medical services regardless of whether such

emergency services are rendered outside the service area covered by the plan. One procedure on the second claim was improperly denied.

- A service line on one claim was denied for "Non-allowed benefit." Heritage later reprocessed and paid the service line.

- For five claims, the amount paid by Heritage was incorrect.
  - For two claims, Heritage did not apply the contracted rate for the service provided.
  - For one claim, Heritage applied an incorrect copayment percentage to four lines of service on the claim, resulting in an underpayment to the medical provider and an overcharge to the TennCare member.
  - For one claim, Heritage incorrectly applied a deductible for a procedure exempt from deductibles, resulting in an underpayment to the medical provider and an overcharge to the TennCare member.
  - For one claim, a service line was denied with no explanation.
- For two pharmacy claims, it could not be determined from the information provided whether the claims were priced correctly.
- The Department of Commerce and Insurance determined from a test of claims received in Heritage's mailroom that there was a two-day time lag between the actual receipt date in the mailroom and the receipt date recorded in the claims-processing system. Proper recording of the receipt date is essential in determining compliance with timely processing requirements of the TennCare contract.

c. Heritage did not fully report encounter data required by the TennCare contract. Encounter data, a record of medical services provided to enrollees, are necessary for evaluation of quality of care and access to TennCare services. The following deficiencies were noted in the 50 claims selected for testing:

- For one claim, a procedure code other than the one on the claim was entered into the system.
- For 15 claims, the number of units entered into the claims-processing system did not agree with the number reported on the claim.
- For five claims, Heritage did not enter all diagnosis codes from the claims medical providers submitted.
- For two claims, the procedure code reported on the claim was not entered into the claims-processing system.

d. Heritage did not meet claims-processing requirements specified by the TennCare contract. Claims submitted by providers for medical services were not always processed within the 60-day requirement. Eight of the 50 claims selected for testing were not processed within 60 days. Also, Heritage failed to pay or deny 95% of the clean claims tested within the 30-day requirement with the remaining 5% or 100% of all clean claims to be paid or denied within ten calendar days. Clean claims are those that can be processed without requiring additional information from the service provider. Of the 50 claims tested, 46 were clean claims with the following time lags:

- 27 claims within 30 days (59%)
- 33 claims within 40 days (72%)

The inaccuracies and inefficiencies of the claims-processing system uncovered by our testing show that Heritage did not fulfill claims-processing requirements of the TennCare contract.

Recommendation

Heritage National Health Plan, Inc., should adhere to contract reporting requirements and processing-efficiency requirements for claims processing. The EOB should clearly communicate to the TennCare members any amount they owe the medical provider. The EOB should never communicate a patient responsibility for Medicaid-eligible members for emergency room services. Deductibles and copayments should not be charged to TennCare "uninsured" members for services the TennCare contract has excluded from application of copayments and deductibles. The proper copayment percentage as determined by the member's eligibility status should always be applied. Claims should be paid according to the correct fee schedule or contract pricing methodologies, and all lines should be processed for payment or denial. All data elements required for individual encounter/claims data reporting should be recorded from claims submitted by providers. The actual receipt date in the mailroom should be recorded as the receipt date in the claims-processing system.

Management's Comment

EOB issues–The Explanation of Benefits (EOB) is being reevaluated. The examples from the audit will be investigated and changes will be suggested for review and implementation.

Processing and payment errors–The implementation of a formalized quality control program allowed accuracy measures to begin in June 1997. These measures help identify possible training issues with a specific processor or within a specific processing unit. A claims audit which includes financial accuracy, payment accuracy, and data accuracy is performed monthly based on a statistically valid random sampling. Individual random audits are done as well. Accuracy levels are now within industry standards.

Receipt date time lag–We acknowledge that this is an issue and have made a business decision that effective January 18, 1999, all TennCare claims will be date-stamped upon receipt in the mailroom. The processing staff will be instructed to input the actual date stamp receipt number in the received field of the medical screen rather than the Julian date number to correct the problem.

Encounter data–System constraints do not allow every field on the HCFA 1500 to be recorded in the system. A review will be done to see what fields are not accounted for in the processing system and what development would need to occur to include this information.

Claim processing timeliness–Since July 1997, a concentrated effort has been made to reduce the number of days required to process claims. We are proactively running weekly turnaround reports and prioritizing adjudication of any and all claims on a daily basis to ensure that we are in compliance.

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2. Deficiencies in provider contract language

Finding

Heritage did not comply with the TennCare contract requirements for provider contracts. Language describing the following requirements was missing or inadequate in contracts between Heritage and medical providers:

- The provider shall render emergency services without requiring prior authorization.

- The provider shall comply with the grievance process and shall provide grievance forms and contact information to the enrollees. The address for the submission of appeals for state review shall also be provided to the enrollees.

- Enrollees have the right to appeal adverse decisions that affect services. Notices of the right to appeal adverse decisions shall be displayed by the provider in public areas of the provider's facility.

- The Contractor shall submit the proposed arbitration procedure, existing alternative arbitration procedure, or any subsequent modification to the arbitration procedure to the Tennessee Department of Commerce and Insurance, TennCare Division, for review and approval/denial within 30 calendar days after receipt. If a modification to the arbitration procedure is sent, it shall be sent certified mail with return receipt requested.

All requirements for provider contracts are specified in section 2-18 of the TennCare contract with Heritage.

Recommendation

Heritage should comply with the TennCare Bureau's requirements regarding provider agreements. The provider agreements should contain all items specified in section 2-18 of the TennCare contract.

Management's Comment

The following requirements were missing or inadequate in contracts between Heritage National Healthplan, Inc., and medical providers. These requirements have been included in the amendments executed with current TennCare providers and will be included in contracts with all future TennCare providers.

- The provider shall render emergency services without requiring prior authorization.
- The provider shall comply with the grievance process and shall provide grievance forms and contact information to the enrollees. The address for the submission of appeals for state review shall also be provided by the provider to the enrollees.
- Enrollees have the right to appeal adverse decisions that affect services. Notices of the right to appeal adverse decisions shall be displayed by the provider in public areas of the provider's facility.
- The Contractor shall submit the proposed arbitration procedure, existing alternative arbitration procedure, or any subsequent modification to the arbitration procedure to the Tennessee Department of Commerce and Insurance, TennCare Division, for review and approval/denial within 30 calendar days after receipt. If a modification to the arbitration procedure is sent, it shall be sent certified mail with return receipt requested.